STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G228	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2420 T STREET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from June 28, 2011 through June 30, 2011. A sample of three clients was selected from a population of six females with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident/investigation reports.	W 000	Received 7/18/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, for one of six clients residing in the facility. (Client #4) The finding includes: The facility failed to ensure Client #4's rights was protected by making certain involved family members and/or legally sanctioned medical	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	COO	7/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	Continued From page 1	W 125		

representatives assisted her with making decisions, as evidenced below:

On June 28, 2011, at approximately 3:30 p.m., Client #4 was observed walking with the assistance of staff into the facility. At 4:40 p.m., Client #4 was observed sitting on the sofa. Approximately one minute later, a loud sound was heard when she [client] attempted to get up off of the sofa. This loud sound was heard each time the client attempted to get up from her seat throughout the survey. Interview with the direct care staff on the same day at 4:43 p.m., revealed that Client #4's alarm was used to let staff know when she got up from her seat.

Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 30, 2011, at approximately 2:45 p.m., revealed that the alarm pad for Client #4 was used for her safety due to her unsteady gait. Further interview with the QIDP revealed that she believed that the facility's Human Rights Committee (HRC) had approved the use of the alarm pad. On June 30, 2011, at approximately 3:00 p.m., review of the HRC minutes from September 2010 through June 30, 2011, revealed that Client #4's alarm pad failed to be addressed.

On June 30, 2011, at approximately 3:15 p.m., continued interview with the QIDP revealed Client #4's mother (surrogate decision-maker) had been made aware of the purpose of the alarm pad and had agreed to its use. A few minutes later, the QIDP stated that there was no written documentation available for review to verify that the client's mother had been involved in the decision making process for the use of Client #4's

The alarm pad was a recommendation by the PT on 2/25/11 at Client #4's 2nd qtrly meeting. The pad was discussed at that meeting with her mother present and she and the team agreed with the use. The alarm pad was approved by the HRC on 3/14/11 (attachment#1) and again on 7/11/11 (attachment #3)due to missing signature sheet from the 3/14/11 meeting. In the future, the QIDP will ensure the signature sheets are available.

Completed 07/11/2011

Client # 4's Mother did sign the consent as of 7/1/11 (attachment #2). In the future the QIDP will ensure a consent is obtained at the time it is approved for any restrictive devise.

Completed 7/1/11

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W 125	Continued From page 2 alarm pad.	W 125		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for one of three clients included in the sample. (Clients #2) The findings include: The facility failed to provide evidence that justified the withdrawals/expenditures from Client #2's personal accounts, as evidenced below: On June 30, 2011, at 12:58 p.m., interview with the Qualified Intellectual Disabilities Professional (QIDP) reveeled that Client #2 went on vacation last year to Williamsburg, Virginia. Further interview revealed that the facility assisted the clients' with maintaining their finances. Review of Client #2's financial records on June 30, 2010, at approximately 1:10 p.m., revealed the following: a. A bank statement dated June 25, 2010, revealed a withdrawal in the amount of $300.00 for vacation spending. Further review revealed $80.00 in receipts and expenditures could not be accounted in the client's financial records. b. A bank statement dated December 2010	W 140	In the future the facility QIDP will submit Client #2 finance records to the Finance Department each month for an audit to ensure all funds are accounted for. RCM will deposit $150 into Client # 2 account to account for the missing receipts. See deposit receipt (attachment #4) Completed 7/14/11	

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W 140	Continued From page 3 revealed withdrawals in the amount of $250.00 and $195.00 for Christmas shopping and clothing. Further review revealed approximately $70.00 in receipts and expenditures could not be accounted in the client's financial records. Continued interview with the QIDP on June 30, 2011, at approximately 1:40 p.m., revealed that she could not locate the receipts that would account for Client #4's missing funds.	W 140		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure that the active treatment program was integrated, coordinated, and monitored, for two of six clients residing in the facility. (Clients #3 and #4) The findings include: 1. Cross refer to W125. The QIDP failed to ensure Client #4's rights was protected by making certain Involved family members and/or legally sanctioned medical representatives assisted her with making decisions. 2. Cross refer to W249. The QIDP failed to ensure Client #3 received continuous and aggressive active treatment services and interventions in accordance with	W 159	See W 125 The QIDP has in-serviced the staff on Client #3 goals on 7/1/11 and is monitoring on a weekly basis. See attachment #6	Completed 7/11/11 Completed 7/01/11

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W 159	Continued From page 4 recommendations made by the interdisciplinary team.	W 159		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that client's received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT), for one of three clients included in the sample. (Clients #3) The finding includes: Observations conducted on June 28, 2011, at approximately 9:10 a.m., revealed that Client #3 was observed sitting in a wheelchair. Further observations revealed the client was observed throughout the remainder of the survey using her wheelchair for mobility. On June 30, 2011, at 10:50 a.m., review of Client #3's records revealed an individual program plan dated October 22, 2010, that included a goal to improve her standing mobility. The IPP stated "the client will stand for 5 minutes every hour that	W 249	The QIDP in-serviced the staff on the PT goal on 7/01/11 and will continue to monitor on a weekly basis for compliance. See attachment #6 Completed 7/01/11	

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W 249	Continued From page 5 she is awake using the rolling walker at 100% accuracy for 6 months". Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 30, 2011, at approximately 10:55 a.m., confirmed that Client #3 had an objective to stand for five minutes every hour that she is awake. Further interview with the QIDP revealed that the objective was to be implemented and documented daily on the data sheets. Review of the June 2011 data collection sheet on June 30, 2011, at 11:00 a.m., revealed the objective was not implemented on June 28 and 29, 2011. Continued interview with the QIDP on the same day at approximately 11:20 a.m. confirmed that data was not collected on Client #3's program on June 28, and 29, 2011.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs for, six of six clients residing in the facility. (Clients #1,#2, #3, #4, #5, and #6) The findings include: 1. Cross refer to W368. The facility's nursing services failed to ensure that all drugs were administered in compliance with the physician's orders. 2. Cross refer to W382. The facility's nursing	W 331	See W 368 See W 382	Completed 6/28/11 Completed 6/28/11

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W 331	Continued From page 6 services failed to keep all drugs locked securely when not being prepared for administration.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on staff observation, interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for one of three clients included in the sample. (Client #1) The finding includes: Observation of the evening medication administration on June 28, 2011, at 7:18 p.m., revealed the Licensed Practical Nurse (LPN) administered Client #1 Lactulose 30 ml by mouth. On June 29, 2011, at 9:09 a.m., review of Client #1's Physician's Order sheet (POS) dated May 31, 2011, revealed an order to administer Lactulose 30 ml each morning for constipation. Interview with the LPN coordinator and the facility's Director of Nursing (DON) on June 28, 2011, at approximately 7:55 p.m., acknowledged that Lactulose 30 ml was not administered on June 28, 2011, in accordance with Client #1's PO's.	W 368	The facility Director of Nursing in-serviced the facility nurses on safe medication administration procedures and cross referencing the PO's with the MAR's on 6/28/11. In the future the DON will monitor monthly. (Attachment #7) Completed 6/28/11	
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for	W 382		

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W 382	Continued From page 7 administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep all drugs locked securely when not being prepared for administration, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: On June 28, 2011, at approximately 6:55 p.m., the Licensed Practical Nurse (LPN) was observed to leave Client #4's medications with the surveyor as she left the medication area to wash her hands in the kitchen. During this time the medication closet door remained unsecured. At approximately 7:17 p.m., the LPN left Client #2's medications with the surveyor as she left the medication area to wash her hands in the kitchen. Again, the medication closet door remained unlocked. Interview with the LPN after medication administration on June 28, 2011, at approximately 7:54 p.m., acknowledged that she had left the medication closet door unlock twice during the medication administration. Interview with the facility's Registered Nurse (RN) on June 28, 2011, at approximately 8:00 p.m., revealed that the medication closet door was required to be locked at all times when medications were not being prepared. At the time of the survey, there was no evidence that the medication closet door was secured when medications were not being prepared.	W 382	The facility Director of Nursing in-serviced the LPN's on proper medication storage on 6/28/11. In the future the DON will monitor the storage of mediations each month. (attachment #8) Completed 6/28/11	

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 28, 2011 through June 30, 2011. A sample of three residents was selected from a population of six females with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with residents and staff in the home and at one day program, as well as a review of client and administrative records, including incident/investigation reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative support to effectively meet the needs of two of six residents residing in the GHPID. (Residents #3 and #4) The findings include: 1. Cross refer to W125. The QIDP failed to ensureResident #4's rights was protected by making certain involved family members and/or legally sanctioned medical representatives assisted her with making decisions. 2. Cross refer to W249. The QIDP failed to ensure Resident #3 received continuous and aggressive active treatment services and	I 180	See W 125 See W 249	Completed 7/11/11 Completed 7/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE COO — (X6) DATE 7/15/11

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I 180	Continued From page 1 interventions in accordance with recommendations made by the interdisciplinary team.	I 180		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Persons with Intellectual Disabilites (GHPID) failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for one of three three residents included in the sample. (Resident #2) The findings include: The facility failed to provide evidence that justified the withdrawals/expenditures from Resident #2's personal accounts, as evidenced below: On June 30, 2011, at 12:58 p.m., interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed that Resident #2 went on vacation last year to Williamsburg, Virginia. Further interview revealed that the facility assisted the residents' with maintaining their finances. Review of Resident #2's financial records on June 30, 2010, at approximately 1:10 p.m., revealed the following: a. A bank statement dated June 25, 2010, revealed a withdrawal in the amount of $300.00 for vacation spending. Further review revealed $80.00 in receipts and expenditures could not be accounted in the resident's financial records.	I 189	See w 140 See W 140	Completed 7/15/11 Completed 7/15/11

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I 189	Continued From page 2 b. A bank statement dated December 2010 revealed withdrawals in the amount of $250.00 and $195.00 for Christmas shopping and clothing. Further review revealed approximately $70.00 in receipts and expenditures could not be accounted in the resident's financial records. Continued interview with the QIDP on June 30, 2011, at approximately 1:40 p.m., revealed that she could not locate the receipts that would account for Resident #2's missing funds.	I 189	See W 140	Completed 7/15/11
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure professional services that included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident for six of six residents included in the sample. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. Observation of the evening medication administration on June 28, 2011, at 7:18 p.m., revealed the Licensed Practical Nurse (LPN) administered Resident #1 Lactulose 30 ml by	I 401	See W 368	Completed 6/28/11

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I 401	Continued From page 3 mouth. On June 29, 2011, at 9:09 a.m., review of Resident #1's Physician's Order sheet (POS) dated May 31, 2011, revealed an order to administer Lactulose 30 ml each morning for constipation. Interview with the LPN coordinator and the GHPID's Director of Nursing (DON) on June 28, 2011, at approximately 7:55 p.m., acknowledged that Lactulose 30 ml was not administered on June 28, 2011, in accordance with Resident #1's PO's. 2. On June 28, 2011, at approximately 6:55 p.m., the Licensed Practical Nurse (LPN) was observed to leave Resident #4's medications with the surveyor as she left the medication area to wash her hands in the kitchen. During this time the medication closet door remained unsecured. At approximately 7:17 p.m., the LPN left Resident #2's medications with the surveyor as she left the medication area to wash her hands in the kitchen. Again, the medication closet door remained unlocked. Interview with the LPN after medication administration on June 28, 2011, at approximately 7:54 p.m., acknowledged that she had left the medication closet door unlock twice during the medication administration. Interview with the GHPID's Registered Nurse (RN) on June 28, 2011, at approximately 8:00 p.m., revealed that the medication closet door was required to be locked at all times when medications were not being prepared. At the time of the survey, there was no evidence that the medication closet door was secured when medications were not being prepared.	I 401	See W382	Completed 6/28/11

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I 422	Continued From page 4	I 422		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that residents received training, habilitation and assistance as prescribed in their individual Support Plan, for one of three residents included in the sample. (Residents #3) The findings includes: Observations conducted on June 28, 2011, at approximately 9:10 a.m., revealed that Resident #3 was observed sitting in a wheelchair. Further observations revealed the resident was observed throughout the remainder of the survey using her wheelchair for mobility. On June 30, 2011, at 10:50 a.m., review of Resident #3's records revealed an individual program plan dated October 22, 2010, that included a goal to improve her standing mobility. The IPP stated "the resident will stand for 5 minutes every hour that she is awake using the rolling walker at 100% accuracy for 6 months". Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 30, 2011, at approximately 10:55 a.m., confirmed that Resident #3 had an objective to stand for five minutes every hour that she is awake. Further interview with the QIDP revealed that the objective was to be implemented and documented daily on the data sheets.	I 422	See W 249	Completed 7/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD-03-028	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2420 T STREET, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 5 Review of the June 2011 data collection sheet on June 30, 2011, at 11:00 a.m., revealed the objective was not implemented on June 28 and 29, 2011. Continued interview with the QIDP on the same day at approximately 11:20 a.m. confirmed that data was not collected on Resident #3's program on June 28, and 29, 2011. Review of the June 2011 data collection sheet on June 30, 2011, at 11:00 a.m., revealed the objective was not implemented on June 28, 29, and part of June 30, 2011. This was acknowledged through continued interview with the QIDP on the same day at approximately 11:20 a.m.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectually Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectually disabilities, for one of three residents residing in the GHPID. (Resident #4) The finding include:	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD-03-028	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 500	Continued From page 6	I 500		

The GHPID failed to ensure Resident #4's rights was protected by making certain involved family members and/or legally sanctioned medical representatives assisted her with making decisions, as evidenced below:

On June 28, 2011, at approximately 3:30 p.m., Resident #4 was observed walking with the assistance of staff into the GHPID. At 4:40 p.m., Resident #4 was observed sitting on the sofa. Approximately one minute later, a loud sound was heard when she [resident] attempted to get up off of the sofa. This loud sound was heard each time the resident attempted to get up from her seat throughout the survey. Interview with the direct care staff on the same day at 4:43 p.m., revealed that Resident #4's alarm was used to let staff know when she got up from her seat.

See W 125 — Completed 7/11/11

Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 30, 2011, at approximately 2:45 p.m., revealed that the alarm pad for Resident #4 was used for her safety due to her unsteady gait. Further interview with the QIDP revealed that she believed that the GHPID's Human Rights Committee (HRC) had approved the use of the alarm pad. On June 30, 2011, at approximately 3:00 p.m., review of the HRC minutes from September 2010 through June 30, 2011, revealed that Resident #4's alarm pad failed to be addressed.

On June 30, 2011, at approximately 3:15 p.m., continued interview with the QIDP revealed Resident #4's mother (surrogate decision-maker) had been made aware of the purpose of the alarm pad and had agreed to its use. A few minutes later, the QIDP stated that there was no written documentation available for review to

See W125 — Completed 7/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD-03-028	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON	2420 T STREET, SE WASHINGTON, DC 20020

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I 500	Continued From page 7 verify that the resident's mother had been involved in the decision making process for the use of Resident #4's alarm pad.	I 500		